



SouthSound  
RADIOLOGY

www.southsoundradiology.com

# DIAGNOSTIC IMAGING OUTPATIENT ORDER FORM

3417 Ensign Road NE • Olympia, WA 98506-5075 • Scheduling (360) 252-9301 • Fax (360) 455-5442

Mail CD to Office

PT to return w/ CD

STAT ORDER

TODAY'S DATE: \_\_\_\_\_

PATIENT NAME (Last, First, M.I.): \_\_\_\_\_ PT's D.O.B.: \_\_\_\_\_

PHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

INSURANCE: \_\_\_\_\_ ID #: \_\_\_\_\_ AUTHORIZATION NO: \_\_\_\_\_

MEDICARE CDS INFORMATION CDSM/G-CODE: \_\_\_\_\_

OUTCOME/MODIFIER: \_\_\_\_\_

IS EXAM DUE TO INJURY?  YES  NO Date of Injury: \_\_\_\_\_ ICD 10: \_\_\_\_\_

HISTORY/Relevant Clinical Diagnosis: \_\_\_\_\_

SYMPTOM(S) / SIGN(S): \_\_\_\_\_

PROVIDER: \_\_\_\_\_ Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Contrast Exams require a Creatinine lab within the past 30 days DATE: \_\_\_\_\_ LAB: \_\_\_\_\_

**MRI / MRA** Circle IV Contrast or Indicate at Rads Discretion  
W/O \_\_\_\_\_ W/ & W/O \_\_\_\_\_ or at Rads. discretion \_\_\_\_\_

<input type="checkbox"/> Brain	<input type="checkbox"/> MRCP		
<input type="checkbox"/> Orbits	<input type="checkbox"/> Shoulder	Lt	Rt
<input type="checkbox"/> IAC	<input type="checkbox"/> MR arthrogram	Lt	Rt
<input type="checkbox"/> MRA Brain			
<input type="checkbox"/> MRA Neck (Carotids)	<input type="checkbox"/> Forearm	Lt	Rt
<input type="checkbox"/> MR Angiogram _____	<input type="checkbox"/> Elbow	Lt	Rt
<input type="checkbox"/> MR Venogram _____	<input type="checkbox"/> Wrist <input type="checkbox"/> Hand	Lt	Rt
<input type="checkbox"/> Soft tissue neck	<input type="checkbox"/> Femur	Lt	Rt
<input type="checkbox"/> C-spine	<input type="checkbox"/> Knee	Lt	Rt
<input type="checkbox"/> T-spine	<input type="checkbox"/> Ankle/Hind Foot	Lt	Rt
<input type="checkbox"/> L-spine	<input type="checkbox"/> Fore Foot	Lt	Rt
<input type="checkbox"/> Chest	<input type="checkbox"/> Mid Foot	Lt	Rt
<input type="checkbox"/> Breast	<input type="checkbox"/> Pelvis <b>OR</b> <input type="checkbox"/> Hip	Lt	Rt
<input type="checkbox"/> Breast Implant Eval	<input type="checkbox"/> TMJ	Lt	Rt
<input type="checkbox"/> Breast Biopsy	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Abdomen			

**CT / CTA** W/ \_\_\_\_\_ W/O \_\_\_\_\_ W/ & W/O \_\_\_\_\_ or at Rads. discretion \_\_\_\_\_

<input type="checkbox"/> Brain	<input type="checkbox"/> Facial bones	<input type="checkbox"/> KUB w/ 1 view ABD x-ray
<input type="checkbox"/> Orbits	<input type="checkbox"/> Temp bones/IAC	<input type="checkbox"/> C-spine
<input type="checkbox"/> Sinus		<input type="checkbox"/> T-spine levels
<input type="checkbox"/> Soft-tissue neck		<input type="checkbox"/> L-spine
<input type="checkbox"/> Chest		<input type="checkbox"/> Upper extr. _____
<input type="checkbox"/> Abdomen & pelvis		<input type="checkbox"/> Lower extr. _____
<input type="checkbox"/> Abdomen Upper Quadrant		<input type="checkbox"/> Post Myelogram CTL
<input type="checkbox"/> Pelvis Lower Quadrant		<input type="checkbox"/> Other _____
<input type="checkbox"/> CTA Chest	<input type="checkbox"/> CTA Abd/Pelv	<input type="checkbox"/> CTA Head/Neck

**ULTRASOUND**

<input type="checkbox"/> OB < 14, <input type="checkbox"/> TV if needed	<input type="checkbox"/> Bladder pre/post void
<input type="checkbox"/> OB > 14 wks (survey)	<input type="checkbox"/> Testicles
<input type="checkbox"/> OB Follow Up	<input type="checkbox"/> Hernia _____
<input type="checkbox"/> OB BPP	<input type="checkbox"/> Musculoskeletal _____
<input type="checkbox"/> Pelvis Transabdominal only	<input type="checkbox"/> Carotids
<input type="checkbox"/> Pelvis Transvaginal & Transabdominal	<input type="checkbox"/> Aorta <input type="checkbox"/> AAA <input type="checkbox"/> Screening
<input type="checkbox"/> Abdomen complete	<input type="checkbox"/> Vascular DVT
<input type="checkbox"/> RUQ/Gallbladder/Liver	<input type="checkbox"/> Thyroid/neck soft tissue
<input type="checkbox"/> Liver elastography	<input type="checkbox"/> Biopsy <input type="checkbox"/> Thyroid <input type="checkbox"/> Lymph node
<input type="checkbox"/> Abdomen vascular study	
<input type="checkbox"/> Renal	<input type="checkbox"/> Hysterosonogram
<input type="checkbox"/> Renal Arterial study	<input type="checkbox"/> Other _____

**X-RAY**

<input type="checkbox"/> Orbits for foreign body	<input type="checkbox"/> Abd 1V <input type="checkbox"/> 2V
<input type="checkbox"/> Sinus waters view <input type="checkbox"/> complete	<input type="checkbox"/> C-spine 2V
<input type="checkbox"/> Chest 2V <input type="checkbox"/> 1V (PA)	<input type="checkbox"/> C-spine w/oblique
<input type="checkbox"/> Ribs Lt Rt	<input type="checkbox"/> C-spine obl, flex & extension
<input type="checkbox"/> Shoulder Lt Rt	<input type="checkbox"/> T-spine
<input type="checkbox"/> Humerus Lt Rt	<input type="checkbox"/> L-spine 2V
<input type="checkbox"/> Elbow Lt Rt	<input type="checkbox"/> L-spine w/oblique
<input type="checkbox"/> Forearm Lt Rt	<input type="checkbox"/> L-spine w/flex & extension
<input type="checkbox"/> Wrist <input type="checkbox"/> Hand Lt Rt	<input type="checkbox"/> Epidural inj Level: _____
<input type="checkbox"/> Finger Lt Rt	<input type="checkbox"/> Facet injection
<input type="checkbox"/> Hip Lt Rt	Levels: _____ Lt Rt
<input type="checkbox"/> Pelvis AP Lt Rt	<input type="checkbox"/> Nerve root injection
<input type="checkbox"/> Femur Lt Rt	Levels: _____ Lt Rt
<input type="checkbox"/> Knee Lt Rt	<input type="checkbox"/> UGI <input type="checkbox"/> SBFT
<input type="checkbox"/> Tib/Fib Lt Rt	<input type="checkbox"/> Barium enema <input type="checkbox"/> BE w/air
<input type="checkbox"/> Foot <input type="checkbox"/> Ankle Lt Rt	<input type="checkbox"/> Barium swallow (esophagram)
<input type="checkbox"/> Heel <input type="checkbox"/> Toes Lt Rt	<input type="checkbox"/> Joint Injection _____
<input type="checkbox"/> Hysterosalpingogram	<input type="checkbox"/> Other _____

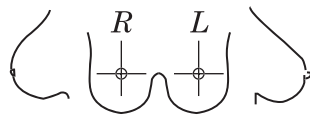
**DEXA**

Bone Density

**BREAST IMAGING**

<input type="checkbox"/> Screening Mammography	<input type="checkbox"/> Ductogram
<input type="checkbox"/> Diagnostic Mammography	<input type="checkbox"/> Ultrasound Breast Cyst Asp
(Breast Ultrasound If Indicated)	<input type="checkbox"/> Needle Loc
<input type="checkbox"/> Breast Ultrasound	<input type="checkbox"/> Consult/Add views if needed
<input type="checkbox"/> Biopsy w/ post biopsy mammogram	

**Other breast imaging at radiologist's discretion including breast ultrasound  NO  YES**

 Document Palp Abn  
O'clock \_\_\_\_\_  
N+ \_\_\_\_\_

**Have priors sent to our office.**

If you are scheduled for an IVP, CT or MRI exam, biopsy or aspiration -- please telephone South Sound Radiology at (360) 252-9301 as soon as you are aware of your appointment. Certain conditions warrant special instruction.

## EXAMINATION PREPARATION

- CT Please telephone South Sound Radiology as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction.
- MRI Please telephone South Sound Radiology as soon as you are aware of your appointment to review exam instructions. Certain conditions warrant special instruction. Wear metal-free clothing and leave valuables at home.
- DEXA Day of exam: No calcium or vitamin supplements. Wear metal-free clothing.
- JOINT/SPINE INJECTION & BIOPSIES ATTENTION: IF YOU ARE A PATIENT ON BLOOD THINNERS AND HAVING ONE OF THESE PROCEDURES, YOU WILL NEED TO CALL FOR PREPARATION INSTRUCTIONS.
- Mammography Use no perfume, body powder, or deodorant on the day of the exam. You will be asked to undress from the waist up for this exam. Please wear a **2-piece outfit** the day of your scheduled appointment.

## ULTRASOUND

- Abdominal Ultrasound For AM appointments do not eat or drink for 8 hours prior to exam. \*If medication requires water a few sips are acceptable. If you are insulin dependent please check with your provider for prep instructions.
- Aorta Ultrasound For AM appointments do not eat or drink for 8 hours prior to exam. \*If medication requires water a few sips are acceptable. If you are insulin dependent please check with your provider for prep instructions.
- Gallbladder/RUQ Ultrasound For AM appointments do not eat or drink for 8 hours prior to exam. \*If medication requires water a few sips are acceptable. If you are insulin dependent please check with your provider for prep instructions.
- Pelvis Ultrasound 1) Drink 32 ounces of water, finish 40 minutes prior to your exam time.  
2) Do not empty your bladder until told to.
- Renal/Bladder Ultrasound 1) Empty your bladder;  
2) Drink 32 ounces of water, finish 40 minutes prior to your exam time.  
3) Do not empty your bladder again.

## OB Ultrasound

- 1<sup>st</sup> Trimester
- 2<sup>nd</sup> Trimester
- 3<sup>rd</sup> Trimester
- Biophysical Ultrasound

## X-RAY

- Colon X-Ray  
(Barium Enema) 1) Drink 32 ounces of water, finish 40 minutes prior to your exam time.  
2) \*Please note that only 2 guests are allowed in the exam room.  
1) Drink 32 ounces of water, finish 40 minutes prior to your exam time.  
No preparation required.  
No preparation required.  
Wear metal-free clothing to your appointment.  
Two days **prior** to exam -- Clear liquids after 12 noon.  
One day **prior** to exam -- Purchase Colyte (a prescription from your doctor) and begin drinking at 3 PM according to manufacturer's directions. Drink the entire solution. If you feel full or nauseated, wait 30 minutes and start again. Nothing to eat or drink after midnight.
- UGI/SBFT Day of exam: Nothing to eat (including gum), drink or smoke after midnight or for 6 hours before your exam.\*

\* **PRESCRIPTION MEDICATIONS CAN BE TAKEN WITH A SMALL AMOUNT OF WATER**